This form can be filled out while viewing in Adobe Acrobat Reader. Then print it and fax or mail to HID.

Medicaid Pharmacy Prior Authorization Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
Health Information Designs

P.O. Box 3210
Auburn, AL 36823-3210

PATIENT INFORMATION

Patient name _____ Patient Medicaid # _____

Patient DOB _____ Patient phone # with area code _____

Nursing home resident ☐ Yes

PRESCRIBER INFORMATION

Prescribing practitioner _____ License # _____

Phone # with area code _____ Fax # with area code _____

Address (Optional) _____
Street or PO Box /City/State/Zip

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

_____
Prescribing practitioner signature **Date**

CLINICAL INFORMATION

Drug requested _____ Strength _____

J Code _____ Qty. per month _____ PA Refills: ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 Other _____
If applicable

Diagnosis or ICD-9 Code* _____ Diagnosis or ICD-9 Code* _____

☐ Initial Request ☐ Renewal ☐ Maintenance Therapy ☐ Acute Therapy

Medical justification _____

☐ **Additional medical justification attached.** **Medications received through coupons and samples are not acceptable as justification.**
***See Instruction Sheet, Section 5**

DRUG SPECIFIC INFORMATION

☐ ADD/ADHD Agents ☐ Alzheimer's Agent ☐ Antidepressants ☐ Antidiabetic Agent ☐ Antihistamine
☐ Antihyperlipidemics ☐ Antihypertensives ☐ Antiinfective ☐ Anxiolytics, Sedatives and Hypnotics
☐ Cardiac Agents ☐ EENT-Antiallergics ☐ EENT-Vasoconstrictors ☐ Estrogens ☐ H2 Antagonist
☐ Intranasal Corticosteroids ☐ Narcotic Analgesics ☐ NSAID ☐ Platelet Aggregation Inhibitors
☐ PPI ☐ Respiratory Agents ☐ Skeletal Muscle Relaxants ☐ Skin & Mucous Membrane Agent ☐ Triptans

List previous drug usage and length of treatment as defined in instructions for drug class requested.

Generic/Brand/OTC _____ Reason for d/c _____ Therapy start date _____ Therapy end date _____

Generic/Brand/OTC _____ Reason for d/c _____ Therapy start date _____ Therapy end date _____

If no previous drug usage, additional medical justification must be provided.

DISPENSING PHARMACY INFORMATION

May Be Completed by Pharmacy

Dispensing pharmacy _____ Provider # _____

Phone # with area code _____ Fax # with area code _____

NDC # _____

NOTE: See Instruction sheet for specific PA requirements on the Medicaid website at www.medicaid.state.al.us

☐ **Sustained Release Oral Opioid Agonist**

Proposed duration of therapy _____ Is medicine for PRN use? ☐ Yes ☐ No
Type of pain ☐ Acute ☐ Chronic Severity of pain: ☐ Mild ☐ Moderate ☐ Severe
Is there a history of substance abuse or addiction? ☐ Yes ☐ No
If yes, is treatment plan attached? ☐ Yes ☐ No
Indicate prior and/or current analgesic therapy and alternative management choices
Drug/therapy _____ Reason for d/c _____
Drug/therapy _____ Reason for d/c _____

☐ **Biological Injectables** ☐ Remicade® ☐ Enbrel™ ☐ Kineret™ ☐ Humira™ ☐ Raptiva™ ☐ Amevive® ☐ Orencia®

Current weight _____ kg.

If rheumatoid arthritis, juvenile rheumatoid arthritis or ankylosing spondylitis, is therapy approved by a board certified rheumatologist? ☐ Yes ☐ No
Prior and/or current DMARD therapy? ☐ Yes ☐ No If yes, attach documentation.
If Crohn's disease, is therapy approved by a board certified gastroenterologist? ☐ Yes ☐ No
If Remicade® is requested for rheumatoid arthritis, will patient be on Methotrexate? ☐ Yes ☐ No
If no, contraindication to use _____
If psoriatic arthritis or plaque psoriasis, is therapy approved by a board certified dermatologist? ☐ Yes ☐ No

For Raptiva, Amevive or Enbrel

Is the patient 18 years of age or older? ☐ Yes ☐ No
Is the patient with chronic moderate to severe plaque psoriasis a candidate for systemic therapy or phototherapy? ☐ Yes ☐ No
Has the patient failed 6 month treatment trials with topicals, generic OTC or brand, within the past year? ☐ Yes ☐ No

☐ **Xenical®**

☐ If initial request Weight _____ kg. Height _____ inches BMI _____ kg/m²
☐ If renewal request Previous weight _____ kg. Current weight _____ kg.
Documentation MD supervised exercise/diet regimen ≥ 6 mo.? ☐ Yes ☐ No Planned adjunctive therapy? ☐ Yes ☐ No

☐ **Erectile Dysfunction Drugs**

Failure or inadequate response to the following alternate therapies:
1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____
Contraindication of alternate therapies: _____

☐ Documentation of vasoreactivity test attached ☐ Consultation with specialist attached

☐ **Synagis®** (Check applicable age, condition and risk factors) Current weight _____ kg.

☐ Gestational age ≤ 28 wks & infant is < 12 months
☐ Gestational age 29-32 wks & infant is < 6 months
☐ Gestational age 33-35 wks & infant < 6 months with AAP risk factors*
☐ Child is < 24 months old with Chronic Lung Disease*
☐ Child is < 24 months old with Congenital Heart Disease*

AND

☐ Currently outpatient with no inpatient stay in the last 2 weeks.

*Document AAP risk factor(s) and/or other required medical justification in the Drug/Clinical Information Section of this form.

☐ **Specialized Nutritionals** Height _____ inches Current weight _____ kg.

☐ If < 21 years of age, record supports that > 50% of need is met by specialized nutrition
☐ If ≥ 21 years of age, record supports 100% of need is met by specialized nutrition
Method of administration _____ Duration _____ # of refills _____

☐ **Xolair®** Current weight _____ kg.

Is treatment recommended by a board certified pulmonologist or allergist after their evaluation? ☐ Yes ☐ No
Is the patient symptomatic despite receiving a combination of either inhaled corticosteroid and a leukotriene inhibitor **or** an inhaled corticosteroid and long acting beta agonist **or** has the patient required 3 or more bursts of oral steroids within the past 12 months? ☐ Yes ☐ No
Has the patient had a positive skin or blood test reaction to a perennial aeroallergen? ☐ Yes ☐ No
Is the patient 12 years of age or older? ☐ Yes ☐ No
Are the patient's baseline IgE levels between 30 IU/ml and 700 IU/ml? ☐ Yes ☐ No
Level: _____ Date: _____
Is the patient's weight between 30 and 150 kg? ☐ Yes ☐ No

FOR HID USE ONLY

❒ Approve request ❒ Deny request ❒ Modify request ❒ Medicaid eligibility verified

Comments _____

Reviewer's Signature Response Date/Hour